Capernaum Pediatric Therapy, Inc. and mptc learn. play. live.

IN-PERSON COURSE

LINKED - Breathing & Postural Control, Part 2

Part 1 must be completed before taking this course.

Patricia (Trish) West-Low, PT, MA, DPT, PCS

October 3-4, 2025

FRIDAY, 7:30 a.m. – 5:00 p.m. | SATURDAY, 7:30 a.m. – 2:00 p.m. Course | Lunch on your own

10 River Park Plaza, St. Paul, MN 55107

Enrollment is limited, so sign up as soon as possible!

COURSE REGISTRATION FORM

NAME:	Click here to enter text.	EMAIL:	Click here to enter text.		
ADDRESS:	Click here to enter text.				
CITY:	Click here to enter text.	STATE:	Click here to enter text.	ZIP:	Click here to enter text.
HOME PHONE:	Click here to enter text.	WORK PHONE:	Click here to enter text.		
CELL PHONE:	Click here to enter text.	(Needed in the event of an emergency scheduling change.)			
DISCIPLINE:	Click here to enter text.	SPECIALTY:	Click here to enter text.		
HOW DID YOU LEARN OF THIS COURSE?	Click here to enter text.				

FEES | CANCELLATION POLICY

FEE: $475. Please submit your registration and payment by **September 22, 2025.** Full refunds offered until **September 12, 2025**; no refunds will be made after this date. For full workshop details, visit Capernaum's website, www.capernaumpeds.com, or contact Bonna Olson, 952-285-2840, or email BonnaO@capernaumpeds.com.

☐ I have read and understand the refund policy. | **BRING:** Pillow, bath towel, beach towel OR yoga mat for floor work.

BILLING

☐ **My check is enclosed.** (Make check payable to *Capernaum Pediatric Therapy, Inc.*)

☐ **Please charge my credit card.** (Please print the cardholder's name and billing address/zip code if different from above.)

NAME:	Click here to enter text.				
ADDRESS:	Click here to enter text.				
CITY:	Click here to enter text.	STATE:	Click here to enter text.	ZIP:	Click here to enter text.
AMOUNT CHARGED:	Click here to enter text.				
I hereby authorize you to charge my:	☐ VISA	☐ MC	☐ DISCOVER #:	Click here to enter text.	
EXPIRATION DATE:	Click here to enter text.	CVV:	Click here to enter text.		

Print Name on Card: _____

Signature (required): _____

Please mail or email your signed registration and payment information to:

Capernaum Pediatric Therapy, Inc., 6625 Lyndale Ave S, Suite 430, Richfield, MN 55423-2373

EMAIL: **BonnaO@capernaumpeds.com** | You may also call in your payment information to **952-285-2840.**